RDS Payment Overview

James Mayhew,
Technical Advisor, EPOG, CMS

JoAnn Sausnock
IT Project Manager, RDS Center

Amount of the Retiree Drug Subsidy Payment

For each qualifying covered retiree in the sponsor's qualified prescription drug plan, the sponsor will receive a subsidy payment of 28% of the allowable retiree costs in the plan year that is attributable to the gross prescription drug costs between the cost threshold and the cost limit.

Gross Prescription Drug Costs

- Non-administrative costs incurred under the plan in the plan year for Part D drugs
- Paid for by either the plan or the retiree

Allowable Retiree Costs

- Gross Prescription Drug Costs that are actually paid
- Minus any manufacturer or pharmacy discounts, chargebacks, rebates and other price concessions
- Paid by the plan, the qualifying covered retiree or on the qualifying covered retiree's behalf

Payment Methodology

- Process outlined in 42 CFR §423.888
- Sponsor elects payment frequency in application:
  - Monthly
  - Quarterly
  - Interim Annual, or
  - Annually
- Cost data to be submitted on the same basis as payment

Submission of Cost Data

- During the course of the plan year, for interim payments, the sponsor must submit a request for payment that includes:
  - Total aggregate gross prescription drug costs for all of its qualifying covered retirees
  - Estimated rebate amount attributable to the gross costs

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Special Rule for Sponsors of Insured Plans

- In lieu of submitting gross cost data (costs incurred under the plan) for interim payments, the sponsor can submit the amount of premium paid for those gross costs of its qualifying covered retirees between the cost threshold and the cost limit
- Sponsors of insured plans must follow the same format for reconciliation as the other sponsors

Policy Goals in Developing Payment Process

- Compliance with §1860D-22 of the Social Security Act and with 42 CFR §423.888
- Keep it administratively simple for plan sponsors
- Keep it flexible to accommodate the various designs of retiree drug coverage
- Make it secure to provide assurance that data will be used appropriately
- Assure that CMS makes correct payments

Interim Payment

JoAnn Sausnock
IT Project Manager, RDS Center

Agenda

- Interim Payment Process
  - Process Flow Diagrams
  - Overview of Required Data
    - Self-Insured Benefit Option
    - Fully-Insured Benefit Option
  - Review Payment Request Examples
- Reconciliation Process

BOA Sends Data to RDS Center

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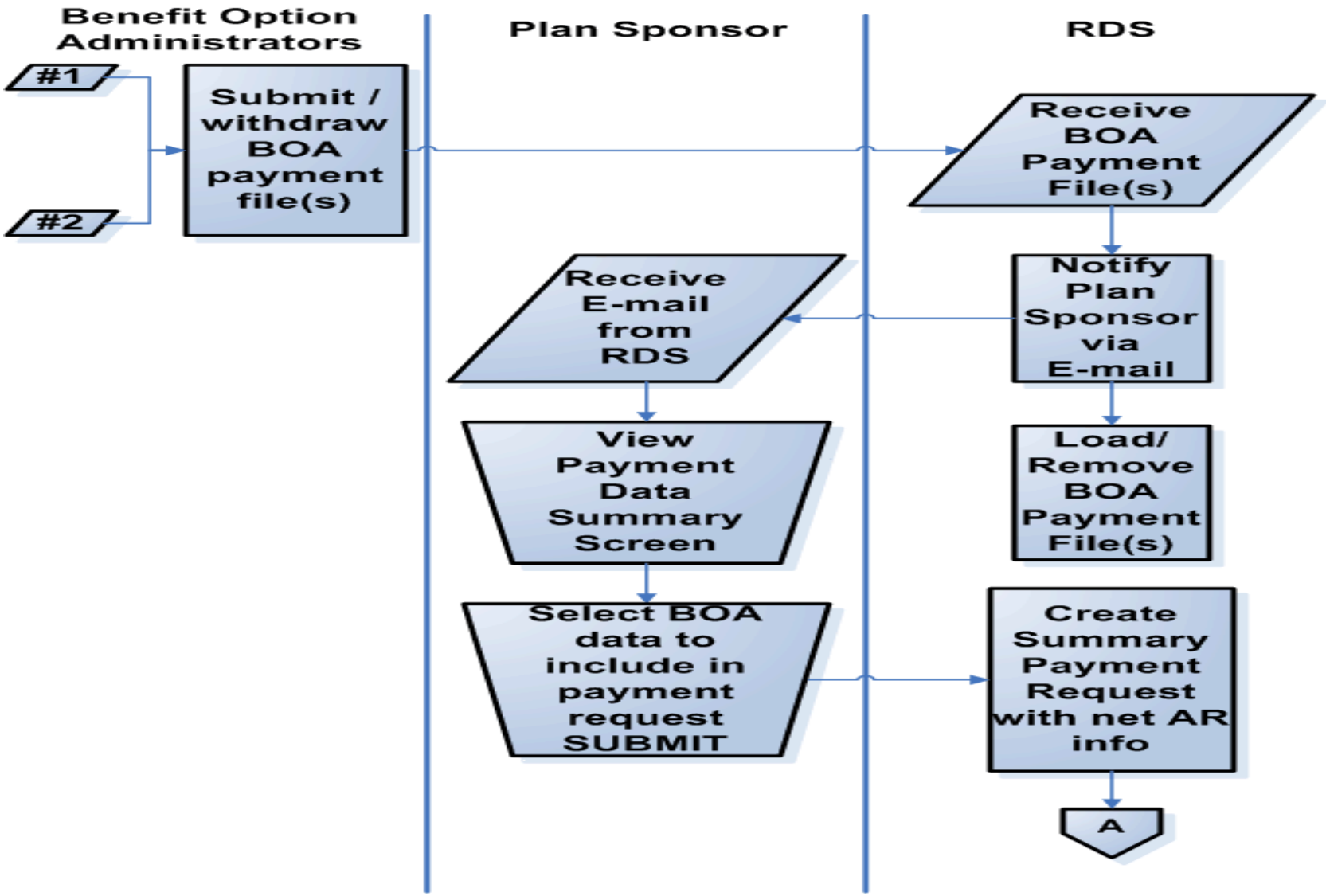

BOA Sends Data to RDS Center

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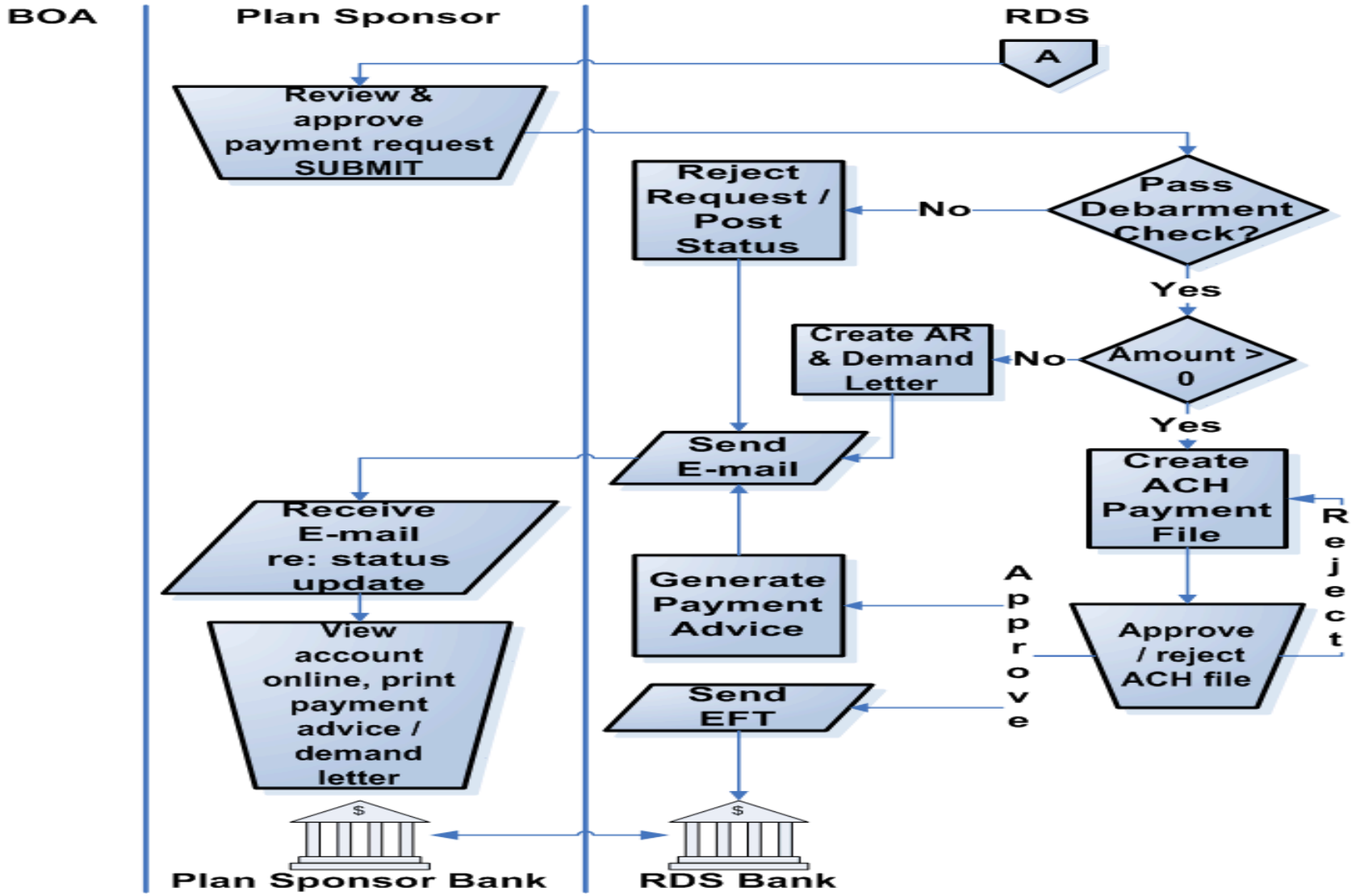
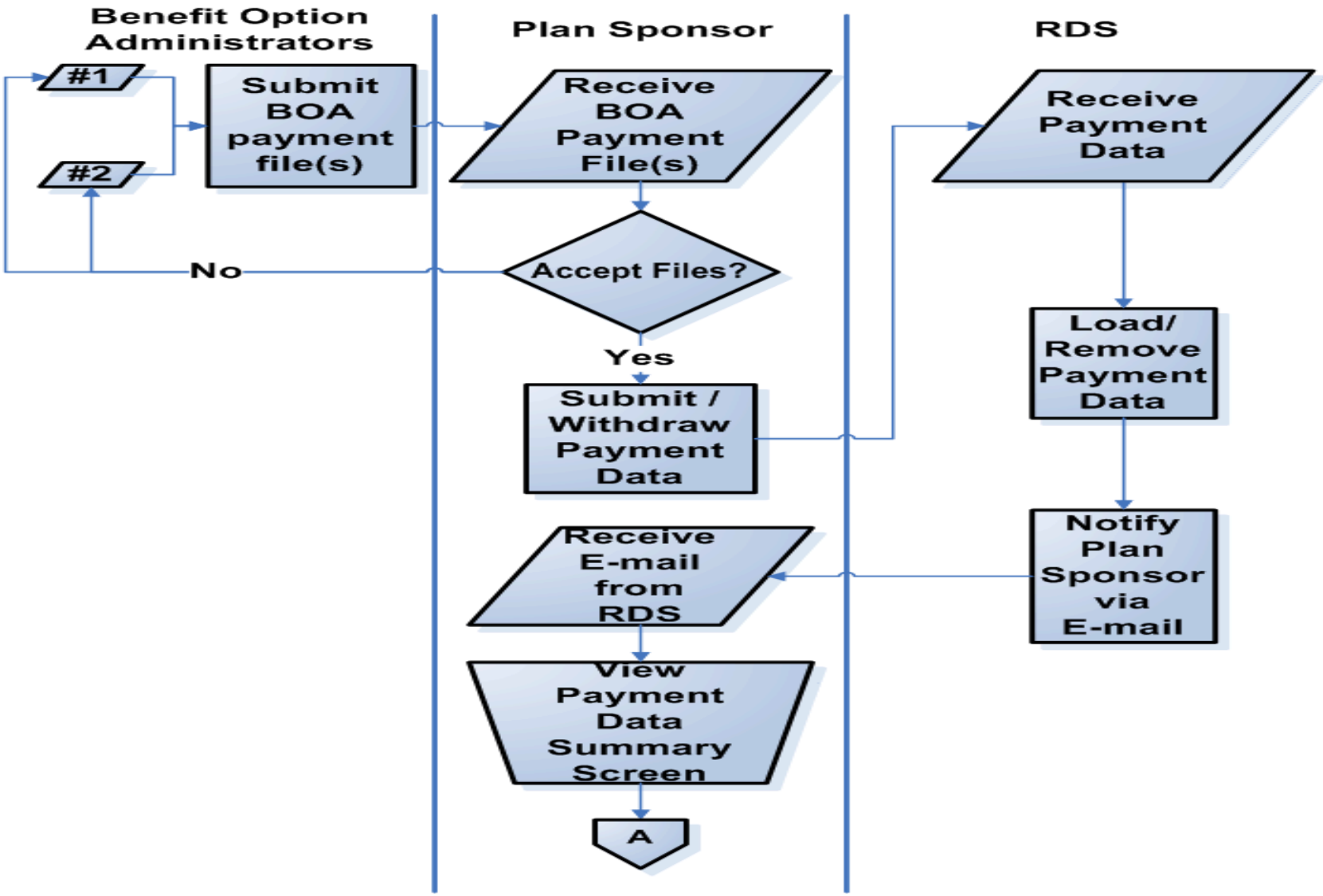
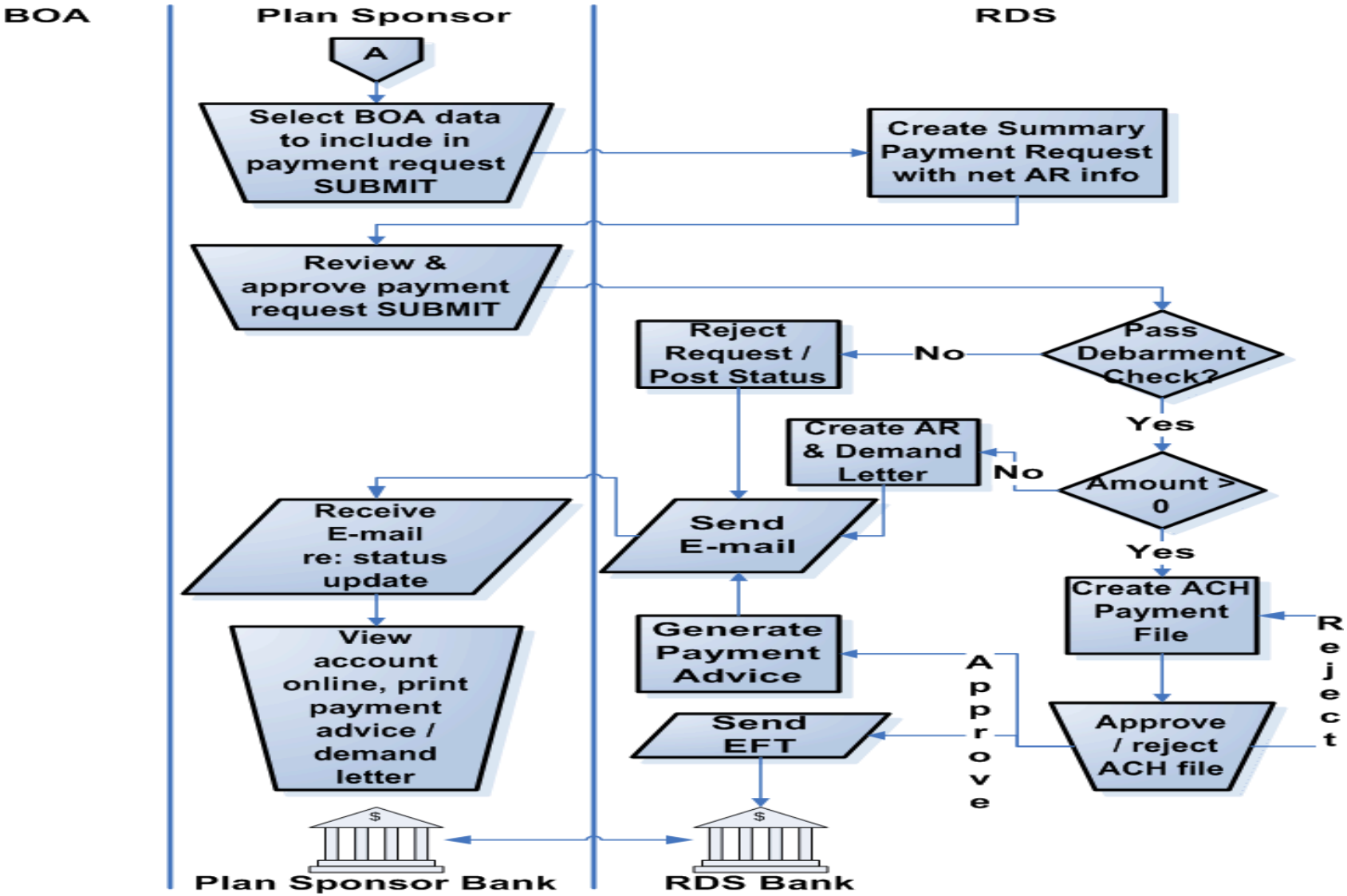


Plan Sponsor Sends Data to RDS Center (continued)



Plan Sponsor Sends Data to RDS Center (continued)



Summary:
RDS Interim Payment Process

- RDS Payment Process will be executed weekly
- Requested Payments will be processed within 30 days after submission
- Payment Processing includes creation of EFT and Payment Notice (Format of Payment Notice has not yet been defined)

Required Data: Self-Insured Benefit Option

- For each benefit option, the following data must be included in the month for which drug costs were paid:
  - Gross Rx Costs Paid
  - Threshold Reduction
  - Limit Reduction
  - Estimated Cost Adjustment

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Example 1A: Self-Insured Payment Request (Month 1)

A	B	C	D	E	F	G	H	I
Month		Gross RX Cost Paid	Estimated Premium Costs	Threshold Reduction	Limit Reduction	Estimated Cost Adjustment	Calculated Allowable Cost	Calculated Subsidy Amount
							(C+D)-(E+F+G)	H * .28 = I
JAN								
	Old							
	New	20,000	0	19,000	0	50	950	266
	Net							
FEB								
	Old							
	New							
	Net							
MAR								
	Old							
	New							
	Net							
APR								
	Old							
	New							
	Net							

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Example 1B: Self-Insured Payment Request (Month 4)

A	B	C	D	E	F	G	H	I
Month		Gross RX Cost Paid	Estimated Premium Costs	Threshold Reduction	Limit Reduction	Estimated Cost Adjustment	Calculated Allowable Cost	Calculated Subsidy Amount
							(C+D)-(E+F+G)	H * .28 = I
JAN								
	Old	20,000	0	19,000	0	50	950	266
	New							
	Net							
FEB								
	Old	25,000	0	12,000	0	650	12,350	3458
	New	24,000	0	11,800	0	610	11,590	3245
	Net	-1,000	0	-200	0	-40	-760	-213
MAR								
	Old	20,000	0	8,000	0	600	11,400	3192
	New							
	Net							
APR								
	Old							
	New	21,000	0	4,000	1,000	800	15,200	4256
	Net							
Based on 100 retirees								
Net payment request would be calculated as $4256 - $213 = $4043, then accounts receivable would be factored in.								

Required Data: Fully-Insured Benefit Option

- **Method #1**
  - Gross Rx Costs Paid
  - Threshold Reduction
  - Limit Reduction
  - Estimated Cost Adjustment
- **Method #2**
  - Estimated Premium Cost
  - Estimated Cost Adjustment (if applicable)

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Example 2A: Fully-Insured Using Method #2 (Month 1)

A	B	C	D	E	F	G	H	I
Month		Gross RX Cost Paid	Estimated Premium Costs	Threshold Reduction	Limit Reduction	Estimated Cost Adjustment	Calculated Allowable Cost	Calculated Subsidy Amount
							(C+D)-(E+F+G)	H * .28 = I
JAN								
	Old							
	New		12,500*				12,500	3,500
	Net							
FEB								
	Old							
	New							
	Net							
MAR								
	Old							
	New							
	Net							
APR								
	Old							
	New							
	Net							

* Based upon 100 retirees with a total annual premium of $3,000, $1,500 of which is attributed to gross prescription Part D drug costs between the cost limit and cost threshold.

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Example 2B: Fully-Insured Using Method #2 (Month 4)

A	B	C	D	E	F	G	H	I
Month		Gross RX Cost Paid	Estimated Premium Costs	Threshold Reduction	Limit Reduction	Estimated Cost Adjustment	Calculated Allowable Cost	Calculated Subsidy Amount
							(C+D)-(E+F+G)	H * .28 = I
JAN								
	Old		12,500*				12,500	3,500
	New							
	Net							
FEB								
	Old		12,500*				12,500	3,500
	New		12,250**				12,250	3,430
	Net		-250				-250	-70
MAR								
	Old		12,250**				12,250	3,430
	New							
	Net							
APR								
	Old							
	New		12,500*				12,500	3,500
	Net							

* Based upon 100 retirees with a total annual premium of $3,000, $1,500 of which is attributed to gross prescription Part D drug costs between the cost limit and cost threshold

** Based upon 98 retirees with the same premium

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Example 3: Combination of Methods #1 & #2 (Month 1)

A	B	C	D	E	F	G	H	I
Month		Gross RX Cost Paid	Estimated Premium Costs	Threshold Reduction	Limit Reduction	Estimated Cost Adjustment	Calculated Allowable Cost	Calculated Subsidy Amount
							(C+D)-(E+F+G)	H * .28 = I
JAN								
	Old							
	New	20,000*	12,500**	19,000	0	50	13,450***	3,766
	Net							
FEB								
	Old							
	New							
	Net							
MAR								
	Old							
	New							
	Net							
APR								
	Old							
	New							
	Net							

* Based upon option with 100 retirees

** Based upon a second fully insured option with 100 retirees with a total annual premium of $3,000 each, $1,500 of which is attributed to gross prescription Part D drug costs between the cost limit and cost threshold

*** Based upon adding $125,000 for the insured option to $950 for the allowable cost of the self-funded option

Reconciliation Process

James Mayhew,
Technical Advisor, EPOG, CMS

Reconciliation Process

Reconciliation Must Be Initiated by Plan Sponsor within 15 months after end of Plan Year

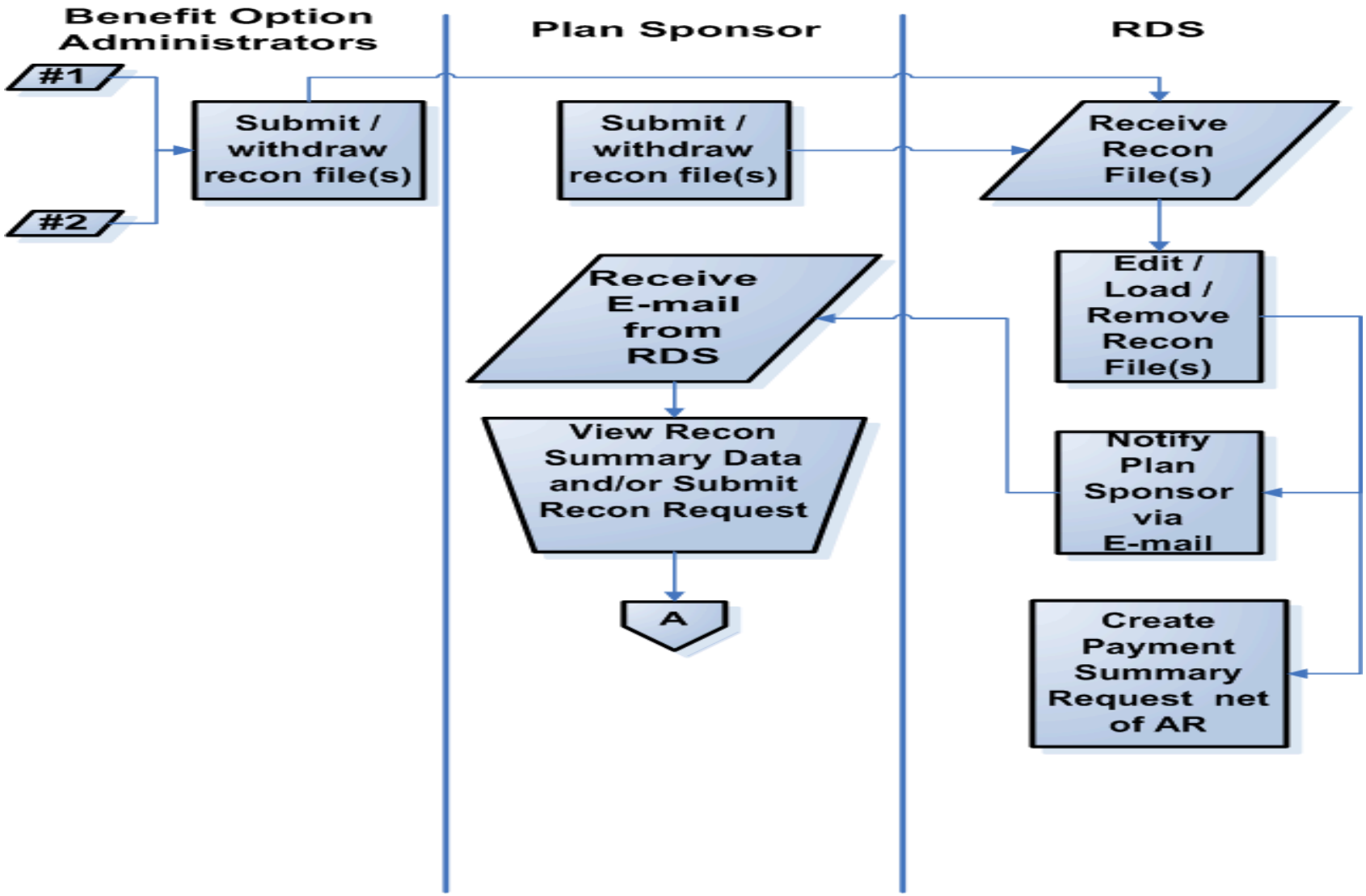
Reconciliation

- Enumerated in 42 CFR §423.888(b)(4)
- Process to capture actual rebate data and to make adjustments for the final payment for the plan year
- Must occur within 15 months after the end of the plan year

Cost Data for Reconciliation

- Sponsor must submit for reconciliation:
  - Total gross prescription drug costs for each qualifying covered retiree
  - Actual rebate amount apportioned to each qualifying covered retiree

Reconciliation Process Flow



Reconciliation Process Flow

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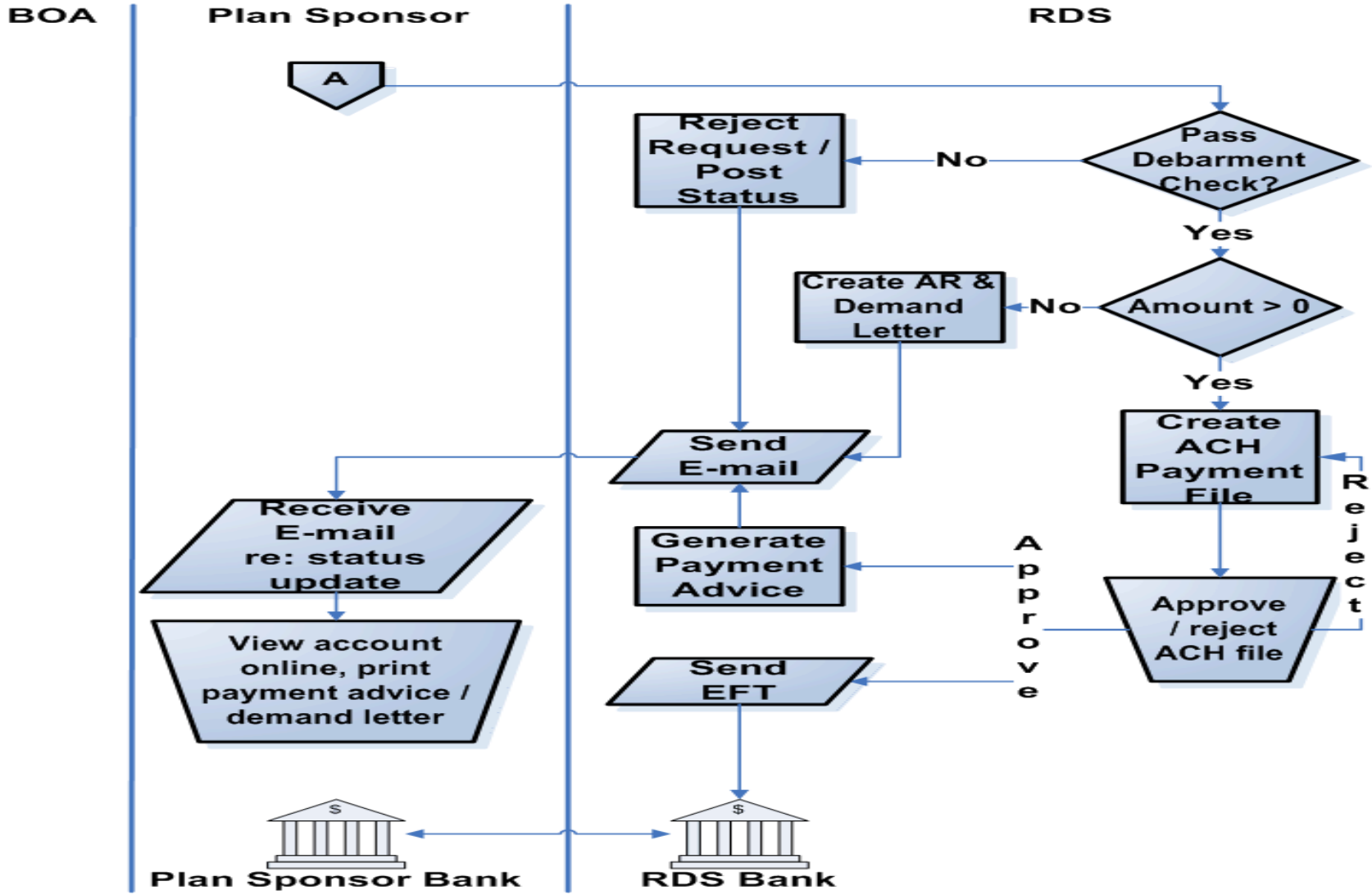

Retiree Drug Subsidy Appeals Process

Patricia Pergal
Chief Legal Counsel, RDS Center

Agenda

- Overview
- What can be appealed?
- Stages of an appeal
  - Content of request
  - How to file an appeal
- Reopenings

Overview

- RDS appeals: 42 CFR 423.890
- All appeals activity: RDS Center secure website
- Filing:
  - In writing
  - Requestors: AR, AM or Designee
  - Ability to submit attachments

Overview (continued)

- Decisions
  - E-mail notification to Requestor
  - Full decision on RDS Center secure website
  - Decisions in favor of Sponsor: implemented within 15 days of determination

Submitting an Appeal

- AR, AM, or Designee signs on to the RDS Secure Web Site
- Go to the Plan Sponsor Application Summary Page
- Select “appeal” action from the drop-down list of actions for the application in question
- Complete form and submit
- Send supporting documentation via fax or US Mail

What May be Appealed?

- Subsidy payment: amount
- Determination: actuarial equivalence
- Eligibility: qualifying covered retirees
- Similar determinations (as determined by CMS):
  - eligibility
  - amount of payment

3 Appeal Levels

- Informal Written Reconsideration
- Informal Hearing
- Review by CMS Administrator (discretionary)

Informal Written Reconsideration

- Must be filed within 15 calendar days of initial determination
- Content:
  - Issues in dispute
  - Reasons for disagreement
  - Supporting evidence (optional)
- Note: Record established at this level of appeal
- Decision final (unless hearing requested)

Informal Hearing

- Available following reconsideration determination
- Must file within 15 days of reconsideration determination
  - Specify issues in dispute
  - Reasons for disagreement
  - No additional evidence allowed
- Conducted by CMS Hearing Officer
- Decision final (unless review by Administrator requested)

Hearing Options

- In person or by telephone
  - Oral argument allowed
  - No testimony
  - Notification of hearing date: at least 10 days prior to hearing
- On the record
- Select option at time of filing

Review by CMS Administrator

- Available following Hearing Officer decision
- Discretionary
- Must file within 15 days of notice of hearing decision
  - Specify issues in dispute
  - Reasons for disagreement
  - No additional evidence allowed
- Decision: final & binding

Reopenings

- Applies to:
  - Initial determinations
  - Reconsideration determinations
- Discretionary: RDS Center decision
- Decision not to reopen: final & binding

Basis for Reopening

- Within 1 year of determination: for any reason
- Within 4 years of determination: for good cause
- Any time: when determination obtained through fraud

Good Cause

- New and material evidence unavailable at time of initial determination
- Clerical error in computation of payments
- Evidence considered in making determination: clearly erroneous on its face

No Good Cause

No Good Cause exists if the only reason for reopening is a change in legal interpretation or administrative ruling upon which initial determination was made.

RDS Appeals
Questions & Answers

CMS

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Retiree Drug Subsidy Program Oversight

James Krall

Health Insurance Specialist, EPOG, CMS

Marilyn Herrington

Fraud & Abuse Manager, RDS Center

David Lamir

Auditor, Office of Inspector General

Agenda

- Overview of benefit integrity activities – RDS Center
- Overview of RDS program audits – CMS
- Overview of Office of Inspector general activities – OIG

Benefit Integrity Goals

- Confirm the identity of individuals and organizations in the RDS program
- Make accurate payments and protect the Medicare Trust Fund
- Detect and prevent fraud and abuse

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BIU Primary Responsibilities

- Respond to complaints of fraud and/or abuse
- Develop cases for referral to law enforcement
- Support law enforcement

What Is Fraud?

Fraud is the *intentional* deception or misrepresentation which an individual *knows to be false* or does not believe to be true and makes, knowing the deception could result in some unauthorized benefit to himself/herself or some other person/entity.

Examples of Potential Fraud in the RDS Program

- Submitting false information on the RDS program application
- Submitting false information regarding retirees in original retiree list and update files
- Creating false or misleading documentation regarding the actuarial equivalence of a plan

Examples of Potential Fraud in the RDS Program

- Submitting false or misleading drug cost data
- Submitting false or misleading data regarding rebates and other price concessions
- Submitting false or misleading documentation when requesting an appeal

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Actions That May Be Taken If Fraud Is Identified

- Referral to the OIG or other law enforcement agency
- Exclusion from participation in Federal programs
- Administrative sanctions
- Civil monetary penalties

Referral To OIG May Result In:

- Possible sanctions or exclusion from all Federal Programs
- Possible Civil Monetary Penalties
- Criminal Penalties which may include:
  - Incarceration
  - Fines/restitution
  - Asset seizure

Situations That May Not Be Fraud

- Making a drug cost calculation or processing error
- Unknowingly submitting incorrect data on rebates
- Unknowingly submitting incorrect information on retirees

What Is Abuse?

Abuse is the incident or practice of plan sponsors that is inconsistent with accepted sound business or fiscal practices. These practices may directly or indirectly result in unnecessary costs to Medicare and/or the RDS program.

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RDS Center Actions When Abuse Is Identified

- Recoup amounts overpaid
  - Demand overpaid amount from plan sponsor
  - Withhold overpaid amount from future claims
  - Suspend payments to plan sponsor
- Education and warnings
- Refer to CMS and/or law enforcement for audit or investigation

Conclusion

- Most plan sponsors will be honest, careful, and conscientious
- Mistakes can and do happen
- The Benefit Integrity Unit will not refer plan sponsors to law enforcement unless there is evidence of fraud

Conclusion

- Remember that when someone commits fraud or abuse, they are taking money from the Medicare trust fund.

- We all share the responsibility of protecting OUR Medicare benefits.

RDS Program Audits

Types of Audits

- Random – plan sponsors will be selected using statistically valid random samples within strata based on plan sponsor size

- Targeted – subjects selected based on information derived or received by CMS from:
  - RDS Center referrals
  - Random audit findings
  - Complaints
  - Law enforcement officials

Audit Categories

- Creditable coverage disclosures
- Actuarial equivalency attestations
- Subsidy payments

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Audits of Creditable Coverage Disclosures

Purpose:

To determine if plan sponsor creditable coverage disclosures are in accordance with the law, regulations, and CMS guidance.

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Audits of Creditable Coverage Disclosures

What will be examined?

- Actual creditable coverage disclosures used by the plan sponsor to notify its retirees (e.g. letters, bulletins, plan benefit booklet)
- Intended target audiences for the disclosures
- Evidence that disclosures occurred

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Audits of Actuarial Equivalency Attestations

Purpose:

To confirm that the plan is at least actuarially equivalent to standard Medicare drug benefit.

Actuarial Equivalency Attestations

What will be examined?

- **Actuary working papers to determine:**
  - If generally accepted actuarial principles were used
  - The accuracy of gross value test calculation(s)
  - The accuracy of net value test calculation(s)

Audits of Subsidy Payments

Purpose:

To confirm the accuracy of plan sponsor payment requests and RDS Center subsidy payments.

Audits of Subsidy Payments

What will be examined?

- RDS Center electronic funds transfers and remittance advices
- Plan Sponsor payment requests
- Source drug claim, rebate, chargeback, price concession, and admin cost data

Audit Open Issues

- How will CMS collect/receive the information needed to complete an audit?
  - Electronic vs. hardcopy?
  - Format of electronic files?
- What proportion of audits will be desk reviews vs. onsite?

Program Oversight
Office of Inspector General

Office of Inspector General

- OIG Mission and Structure
- Regulatory Authority
- OIG and the RDS Program